

Exploring Legal Restrictions, Regulatory Reform, and Geographic Disparities in Abortion Access in Thailand

GRADY ARNOTT, GRACE SHEEHY, ORAWEE CHINTHAKANAN, AND ANGEL M. FOSTER

Abstract

Despite decades of advocacy among Thai governmental and nongovernmental actors to remove abortion from the country's 1957 Criminal Code, this medically necessary service remains significantly legally restricted. In 2005, in the most recent regulatory reform to date, the Thai Medical Council established regulatory measures to allow a degree of physician interpretation within the confines of the existing law. Drawing on findings from a review of institutional policies and legislative materials, key informant interviews, and informal discussions with health service providers, government representatives, and nonprofit stakeholders, this article explores how legal reforms and health policies have shaped the abortion landscape in Thailand and influenced geographic disparities in availability and accessibility. Notwithstanding a strong medical community and the recent introduction of mifepristone for medication abortion (also known as medical abortion), the narrow interpretation of the regulatory criteria by physicians further entrenches these disparities. This article examines the causes of subnational disparities, focusing on the northern provinces and the western periphery of Thailand, and explores strategies to improve access to abortion in this legally restricted setting.

GRADY ARNOTT, MSc, LLB(c), is a law student at the London School of Economics and Political Sciences, UK.

GRACE SHEEHY, MSc, is a 2015–2016 fellow with Cambridge Reproductive Health Consultants.

ORAWEE CHINTHAKANAN, MD, MPH, is a clinical instructor in the Reproductive Health Division of the Obstetrics and Gynecology Department at Ramathibodi Hospital, Mahidol University in Bangkok, Thailand.

ANGEL M. FOSTER, DPhil, MD, AM, is the 2011–2016 Endowed Chair of Women's Health Research and an Associate Professor in the Faculty of Health Sciences at the University of Ottawa, and Principal and Co-Founder of Cambridge Reproductive Health Consultants.

Please address correspondence to Angel M. Foster. Email: angel.foster@uottawa.ca.

Competing interests: None declared.

Copyright © 2017 Arnott, Sheehy, Chinthakanan, and Foster. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

Introduction

For decades, legal and regulatory strategies to expand the availability and accessibility of abortion services in Thailand have run parallel to public debate and political mobilization. Although abortion is legally restricted in the Southeast Asian country, both safe and unsafe abortion are widespread and common among all socioeconomic groups. Public hospital data reveal that each year approximately 30,000 abortions take place in Thailand, yet most abortions are carried out in private sector facilities, in unmarked abortion clinics, or by self-induction; consequently, 300,000 to 400,000 abortions likely occur each year.¹ Through the Centre of Excellent Health Care of Asia Initiative, the Thai government has worked to position the country as a global hub for medical tourism and advanced medical practice.² Therefore, that the national abortion case-fatality rate is still as high as 300 deaths per 100,000 abortions is of great public health concern.³ However, this rate differs throughout the country, as legal, policy, and social factors have converged to shape the national and subnational abortion context.

Using content and thematic analyses, this paper draws on findings from a review of institutional policies and legislative materials, key informant interviews, and informal and formal discussions with stakeholders to explore dynamics shaping subnational differences in abortion availability and access. Between July and October 2016, we conducted six in-depth interviews with key informants who are working to expand safe abortion efforts in Thailand; these included health care providers, government workers, and advocates from the non-profit sector. We conducted our interviews in Thai and subsequently summarized and translated them into English. In addition, we collected responses to a short questionnaire from 32 members of a safe abortion referral program. Questions focused on their experiences providing abortion care in Thailand and the integration of medication abortion into their hospital or clinic. We also draw from our informal discussions with stakeholders—including health service providers, government representatives, and nonprofit actors—that took place from 2014 to 2016 in several regions of Thailand.

We begin this paper by critically examining attempts at abortion law reform that have occurred over the last 40 years in Thailand, as well as recent efforts to address abortion restrictions through regulation. We then explore the compounding sociopolitical and cultural factors that influence the interpretation and implementation of abortion law in various regions of the country. These complex dynamics have resulted in persistent urban-rural disparities in the availability of abortion care, regional and subnational inequalities in the distribution of providers, and inequities in access to safe and legal services among different populations residing in the Thailand-Burma border region. Finally, we discuss advocacy measures and new initiatives in clinical practice at the national and local levels and argue that given the limited political appetite for federal legal reform, these alternative strategies to support women's reproductive rights may be more successful.

Origins of abortion law in Thailand and legal status today

Thailand's abortion law

Following a decade of widespread legislative reforms and revisions to Thailand's Criminal Code, the absolute prohibition of abortion ended in 1957. Sections 301–303 of the 1957 Criminal Code state the circumstances under which a woman, procurer, or provider can be penalized. If the abortion is obtained with the woman's consent and results in her death, the provider may be fined up to THB20,000 (approximately US\$600) or imprisoned for up to 10 years.⁴ Moreover, according to Section 304, if the abortion is unsuccessful in ending the pregnancy, neither the woman nor the provider is subject to criminal penalties.⁵ Yet, in *Attorney General's Office v. Comemoon* (2014), the Supreme Court of Thailand upheld the convictions of two defendants for intent to distribute nonregistered anti-progestogens to a woman seeking an abortion and to organize a place for the medication to be consumed.⁶ This decision is consistent with an overarching trend: legal action is more likely to be taken against non-qualified individuals who provide abortion without a

medical license or participate in the distribution of black-market medications than against qualified physicians. Non-qualified individuals providing abortions without a license can be convicted under the Hospitals Act 2541.⁷

Under Section 305 of the Criminal Code, abortion is permitted only under certain circumstances, including when the pregnancy threatens the woman's life or health, resulted from rape or incest, or occurred when the girl was under the age of 15 and therefore unable to consent to sex.⁸ Throughout the 1970s, political activists lobbied to expand the grounds for legal abortion and joined with the medical community, lawyers, and academics to advocate for abortion law reform.⁹ In 1981, these groups successfully lobbied the House of Representatives to pass the Abortion Bill, legislation that permitted abortion in cases of physical and mental health risks to the woman, fetal deformation, contraceptive failure in cases where counseling and contraceptive provision was conducted by a qualified medical provider, rape, and incest.¹⁰ Per the legislative process in Thailand, after a bill passes in the House of Representatives, the Senate and the King must approve it in order for it to become law. The Abortion Bill was met with exceptional opposition mobilized by a coalition of religious organizations throughout Thailand and by Major General Chamlong Srimuang, a senator and the secretary-general of Phalang Tham, a Buddhist political party.¹¹ Chamlong successfully led the public campaign to block the Abortion Bill from passing in the Senate and set the tone for how future legal reform efforts throughout the 1980s would be opposed.¹²

Attempts to reopen abortion law reform

In the late 1980s, the HIV epidemic in Thailand reached its peak and began to affect the general population, including "housewives" and children; this garnered public support for Parliament to revisit abortion legislation for people living with HIV.¹³ However, Chamlong and his supporters framed these efforts as seeking to provide "free abortion" and encouraging sexual deviance and promiscuity, and they were thus able to successfully diminish

public support for abortion reform.¹⁴ These anti-choice efforts also effectively framed abortion as an immoral act known as *bap*, which is consistent with a strict Buddhist interpretation of abortion. Given that 98% of Thais identify as practicing Buddhists, much of the discourse surrounding abortion reform is influenced by Buddhist religious traditions and social thought.¹⁵ However, most moderate Thai Buddhists agree with a "middle path" interpretation that allows abortion in some circumstances not currently permitted by law, including when the woman has mental health problems or is carrying a fetus at risk of severe hereditary disease.¹⁶

Introduction of regulatory reforms

In 1999, Thailand's Ministry of Public Health conducted a study, supported by the World Health Organization, on unsafe abortion in Thailand. The findings suggested that unqualified providers performed nearly 30% of all abortions in Thailand, leading to considerable morbidity and mortality.¹⁷ A strong desire for policy advocacy and reform to improve sexual and reproductive health, and the safety of abortion in particular, resulted from this high-impact study. Participants in consultative workshops and seminars determined that the non-government-affiliated Thai Medical Council would be the most effective independent body to lead policy recommendations for population health reforms. This consensus stemmed from recognition that past reform attempts at the national legislative level had failed and the capacity within ministerial departments was limited. The resultant task force of the Thai Medical Council researched and launched a series of supplemental regulations over a five-year period.¹⁸ According to its "Regulation on Criteria for Performing Therapeutic Termination of Pregnancy in accordance with Section 305 of the Criminal Code," legally permissible circumstances for abortion include the following:

1. *Necessity due to the physical health of the pregnant woman;*
2. *Necessity due to mental health problems that are certified or approved by at least two medical practitioners, including the one who will perform the abortion; and*

3. *Severe stress due to the finding of fetal disability or high risk of severe genetic disease. The pregnant woman should be clinically documented as having a mental health problem and this should be acknowledged in writing by at least one medical practitioner other than the one performing the abortion.*¹⁹

Further, between January and October 2016, Thai authorities confirmed 392 cases of Zika, including 39 cases involving pregnant women.²⁰ In October 2016, Thailand was the first country in Asia to issue guidance related to Zika surveillance and treatment, which included making abortion permissible through 24 weeks on a case-by-case basis. Although the application of these new guidelines has yet to be fully documented, the legal permissibility for abortion on these grounds appears to fall within the Thai Medical Council regulations related to mental health and severe stress.

Accessibility of abortion in Thailand

Subnational regional disparities

An alliance of stakeholders throughout Thailand, including medical societies and Thai and international nongovernmental organizations (NGOs)—such as PATH, Tamtang, Women Help Women, the Women’s Health and Reproductive Rights Foundation of Thailand, and the Population and Community Development Association—has long advocated for policy reform and continues to address gaps in abortion services. Comprehensive sexual and reproductive health care is supplemented by the Planned Parenthood Association of Thailand and the Population and Community Development Association, which provide contraceptive counseling, contraceptive supplies, and, in some contexts, safe abortion care. However, these organizations are limited by capacity, funding, and geographic reach, leading many low-income women to seek clandestine abortion care or to use district hospital facilities as a primary point of contact.²¹ Women with economic means often go to private clinics for abortion care, which are generally located in urban centers. At these clinics, a manual vacuum aspiration procedure can cost

up to THB5,000 (approximately US\$150), while a medication abortion using mifepristone and misoprostol costs approximately THB500 (US\$15), an amount that is still roughly 1.5 times the daily minimum wage.

National efforts to reduce regional disparities and increase access to abortion services are also spearheaded by the Referral System for Safe Abortion (RSA). The RSA is a multidisciplinary group of pro-choice physicians, counselors, advocates, and nurses that addresses gaps in abortion provision, unites advocates for reproductive choice, and coordinates the activities of medical professionals. Its main goal is to refer women with unwanted pregnancies to qualified legal providers near their place of residence. The RSA also accepts referrals from and supports a government-sponsored telephone hotline that provides non-judgmental, non-directive counseling and medically accurate information about pregnancy options, including abortion. RSA has members in all areas of Thailand, yet not all members are clinicians capable of performing abortions; in addition, some are physicians trained in abortion provision but who work at a facility where abortion care is limited. During our informal stakeholder discussions, RSA members indicated that the single most important factor for whether abortion was provided at their place of work was whether members of the upper-level administration were fellow participants in the RSA. RSA members claim that their participation in the network is driven by their commitment to improving public health in Thailand, their desire to mitigate social consequences resulting from unwanted pregnancies, and the reciprocal support they receive from other practitioners in the system who support reproductive freedom.

In the questionnaire we distributed to RSA members, most respondents reported that health care providers’ attitudes significantly shape whether abortion is available at a clinic or hospital. This is especially salient for senior medical administrators, such as hospital directors, who may control institutional hospital policies and the purchasing of equipment and commodities. If hospital leadership does not support abortion provision, physicians—

particularly junior medical staff—are limited in their ability to provide legal abortion care.

In medical facilities located in both northern and southern Thailand, providers reported that the Thai Medical Council regulations are narrowly interpreted and that use of the mental health exception is limited. The strong institutional culture against abortion is often rooted in religious grounds and conscientious objection stemming from the Buddhist faith or, in the case of the southern provinces, the Muslim faith. However, conscientious objection appears to be clustered in centralized hubs and medical facilities in specific regions. The negative response from regional medical communities to the registration of Medabon, a combination package of mifepristone and misoprostol, demonstrates how subnational disparities in abortion provision can be influenced by geographically concentrated conscientious objectors.²²

Medabon was registered in Thailand in late 2014. The registration specified that the medication abortion combination package can be provided only in government hospital facilities and only to women with a pregnancy of up to 9 weeks' gestation and, in some cases, up to 15 weeks' gestation. In addition, nine facilities have permission to participate in a multicenter trial to monitor Medabon's integration into the health care system and to assess acceptability among patients and providers. However, no hospitals in the urban center of Chiang Mai have applied to the Ministry of Public Health to integrate Medabon into their services or have joined the multicenter trial. That the second-largest metropolitan area in Thailand lacks the gold standard for medication abortion care suggests that the country's abortion divide is not merely urban-rural.

Although medical providers who conscientiously object to providing abortion are expected to refer eligible patients to another provider or facility, they do not always do so. Instead, women seeking abortion care, even in cases that clearly fall within the legal exceptions, may be reprimanded for committing *bap* and breaching Buddhist moral principles. Such dynamics within hospital and clinic environments, especially among leadership personnel, pose significant barriers to women's

ability to access safe and legal abortion care, forcing them to seek care in the private sector or from a non-qualified provider.

Peripheral disparities: The Thailand-Burma border

The border that Thailand shares with Burma is a regionally unique peripheral space that also reflects subnational disparities in abortion access. Burma's long history of military rule and civil conflict, combined with poor economic opportunities, has led to significant in-country and international population displacement. Burma's 2011 elections represented a watershed moment in which a nominally civilian government came to power and subsequently enacted a series of political and legal reforms that have contributed to rapid change and growth in the country. The 2015 elections installed a democratically elected government and renewed optimism for peace and prosperity. However, many migrants and refugees have now lived in Thailand for decades, and economic opportunities in Thailand continue to draw large numbers of people from Burma. Displaced populations from Burma reside in Thailand as documented and undocumented migrants and as refugees in the nine unofficial camps located along the border. Thailand has not ratified the 1951 Refugee Convention and thus does not recognize the status of these refugees or the authority of the non-government-authorized camps.²³ Another subset of the Burmese population is often referred to as "cross-border," or people who occasionally cross into Thailand to seek temporary economic opportunities or medical care. Women from Burma who seek sexual and reproductive health care in Thailand face several unique and compounding challenges, including their migratory status, language barriers, and an increased risk of being subjected to sexual violence or exploitation.²⁴ Their access to safe abortion care, even in circumstances where the procedure is legally permissible, is significantly restricted.²⁵

Abortion laws in Burma, which persist from the 1860 Burma Penal Code, are some of the most restrictive in the world. Abortion is prohibited in all cases, except when necessary to save the pregnant woman's life.²⁶ Furthermore, anyone who provides

an unauthorized abortion is subject to significant fines and to imprisonment; both criminal and civil penalties increase if the abortion takes place after “quickening.”²⁷ Anecdotal evidence suggests that stakeholders in Burma, including clinicians and policy makers, recognize the consequences of unsafe abortion on women’s health and lives and are open to discussing models of legal reform, but acknowledge the minimal likelihood that the law in Burma will change anytime soon.²⁸ Research shows that women in Burma use unsafe methods to end their pregnancies.²⁹ In eastern Burma near the Thai border, the lack of health services, limited capacity of health service professionals, and marginalization of ethnic minority populations further compound the consequences of unsafe abortion.³⁰

Several initiatives have been established to reduce harm from unsafe abortion and help women from Burma obtain safe and legal abortion care in Thailand. For example, a referral system between Burmese community-based organizations and the district Thai government hospital in Mae Sot was established to refer eligible women to a qualified provider for safe and legal abortion care and is now being expanded.³¹ In addition, the RSA and the government-sponsored hotline have a small number of members in the western provinces. Although women seeking advice regarding unintended and unwanted pregnancies would need to be sufficiently fluent in Thai to communicate with the Thai hotline staff, it is an additional resource that has the potential to disseminate information about safe and legal abortion care.

Efforts in Mae Sot, Thailand, are challenged by limited opportunities for abortion provision at the local hospital. Indeed, there is only one medical provider at the district hospital who is willing to perform abortions up to 12 weeks’ gestation; further, the service is available only one day a week.³² This poses a number of difficulties. First, for displaced women, many of whom are domestic or factory workers, travelling into the Mae Sot center on one specific day may be difficult and costly. Second, the eligibility criteria are interpreted narrowly at this district hospital, and abortion care on mental health grounds is rarely provided. Finally, given the

reliance on one provider, patients who have been approved for a legal abortion must wait until the doctor is available. Our informal discussions with the community-based organization referral team suggested that if a woman’s pregnancy surpasses 12 weeks’ gestation while waiting for an appointment, she will be denied services.

Reducing subnational disparities in abortion provision

The disparities in abortion service availability in Thailand are influenced by socio-cultural taboos, the religious beliefs and moral positions of providers and politicians, and the resource capacities of facilities and health service professionals. Importantly, of all the obstetricians and gynecologists trained and practicing in Thailand, 65% work in the metropolitan areas around Bangkok, which has a population of 10 million. The rest of the obstetrician-gynecology workforce is distributed throughout the country and serves 55 million people.³³ Bangkok has become the primary site for abortion provision in Thailand and is widely known to be home to a number of providers who interpret the Thai Medical Council regulations, particularly the mental health exception, broadly. However, for women in border or rural regions for whom travel to the capital is legally restricted or cost prohibitive, it may be nearly impossible to access a safe abortion in Thailand.³⁴ Women’s access to services is additionally shaped by whether they are knowledgeable of available public and private sector services in their area. Again, outcomes are highly dependent on the geographic and economic status of the woman.³⁵ In order to lessen these disparities in Thailand, provider distribution must be addressed—specifically the distribution of qualified Thai providers who offer abortion care to the fullest extent possible under law.

Government policies concerning the funding and availability of commodities for medication abortion must also be addressed to reduce subnational differences. The National Health Security Office (NHSO) established the first universal health coverage scheme in Thailand in 2001; this scheme

provides free public health care at the point of service.³⁶ Since the launch of the universal scheme, the decentralization of family planning program management to district-level health networks has resulted in an increased patient preference for oral contraceptives and a decreased uptake of long-acting reversible contraceptive methods, especially among young, unmarried women.³⁷ However, the fact that contraception is no longer fully subsidized through the program poses significant barriers for women who seek high-quality methods to prevent unintended pregnancy. Post-abortion care is widely available in Thai government hospitals and is fully covered under the national health insurance program.³⁸ However, abortion has never been insured through the NHSO, with the narrow exception of specific fetal anomaly cases. To address these limitations, future advocacy efforts should call for coverage of the full range of contraceptive methods and abortion services under the universal scheme.

Government recognition of abortion as a medically necessary procedure that is eligible for coverage under the NHSO is needed to address economic barriers. Furthermore, the key informants we spoke with reported that establishing more effective referral networks from small clinics to hospitals that offer induced abortion services may prove an important strategy for expanding access. In addition, more small clinics should be encouraged to apply to the Ministry of Public Health for access to Medabon for medication abortion. Research and training conducted by the Women's Health and Reproductive Rights Foundation may be influential in persuading such smaller clinics to incorporate early-induced abortion using misoprostol alone, Medabon, or manual vacuum aspiration. Long-term capacity building in public district hospitals and clinics should be prioritized in order to reduce subnational disparities.³⁹ This may be particularly relevant for marginalized and vulnerable groups, including young women, rural and ethnic minorities, and Burmese populations residing in or seeking medical care in Thailand.

Finally, despite legal restrictions, access to abortion services in rural or low-capacity centers remains a challenge for achieving parity in abortion

care across Thailand. The 2014 registration of Medabon presents a window of opportunity to improve access throughout the country. However, according to well-positioned key informants, there appears to be a general lack of interest in applying for Medabon through institutional hospital procurement processes. If this gold standard for medication abortion care is available only on the basis of the religious or political motivations of hospital management, then it is unlikely that Medabon can achieve the uptake necessary to reduce disparities throughout the country. Sustained partnerships between civil society groups and the medical community are key for addressing these gaps. The active role of these actors in building a case for Medabon registration and the ongoing success of the RSA program and the government-sponsored hotline demonstrate that there may be opportunities for scaling up medication abortion provision throughout Thailand. Further, district hospitals, in particular, should be encouraged to apply for access to Medabon and to train providers in its use. RSA membership should also be encouraged for clinicians working at small clinics in areas where abortion is underprovided.

Conclusion

The country's move toward regulatory reform through the medical profession, which now permits abortion if a woman's physical or mental health is at risk, suggests that in the absence of a political appetite for legal reform, stakeholder advocacy can succeed through other channels. However, considerable barriers continue to impede women across the country from obtaining safe and legal abortion care. In particular, women living outside of Bangkok, where the majority of providers are located and where the law is most generously interpreted, may lack access to safe abortion care when the pregnancy threatens their physical or mental health. The case of Thailand also makes evident that legal reforms alone are insufficient to ensure access to safe abortion care and must be accompanied by efforts to increase the availability of and access to the procedure.

Acknowledgments

We would like to thank Channarong Intahchomphoo for his invaluable assistance with data collection, case law research, and translation. We are grateful to the Society of Family Planning and an anonymous individual donor for their financial support of this project. Angel Foster's 2011–2016 Endowed Chair in Women's Health Research was funded by the Ontario Ministry of Health and Long-Term Care, and we appreciate the general support for her time that made this project possible. The conclusions and opinions expressed in this article are those of the authors and do not necessarily represent the views of the organizations with which the authors are affiliated or the funders.

References

1. K. Chaturachinda, "Unsafe abortion in Thailand: Roles of RTCOG," *Thai Journal of Obstetrics and Gynaecology* 22/1 (2014), pp. 2–7.
2. N. Thinakorn, J. Hanefeld, and R. Smith, "Medical tourism in Thailand: A cross-sectional study," *Bulletin of the World Health Organization* 94/1 (2016), pp. 30–36.
3. Chaturachinda (see note 1), p. 2.
4. Thailand Criminal Code (1860), §§301–303.
5. *Ibid.*, §304.
6. *Attorney General's Office v. Comemoon* (2014), 4482/2556 (Supreme Court of Thailand).
7. *Attorney General's Office of the Nongbua Lamphu Province v. Pratumkhet* (2008), 9283/2551 (Supreme Court of Thailand).
8. Thailand Criminal Code (1860), §305.
9. A. Whittaker, "The struggle for abortion law reform in Thailand," *Reproductive Health Matters* 10/19 (2002), pp. 45–53.
10. *Ibid.*, p. 48.
11. N. Boonthai, S. Tantivess, V. Tangcharoensathien, et al., "Improving access to safe termination of pregnancy in Thailand: An analysis of policy developments from 1999 to 2006," in A. Whittaker (ed), *Abortion in Asia: Local dilemmas, global politics* (New York: Berghahn Books, 2010).
12. *Ibid.*, p. 222.
13. *Ibid.*, p. 223.
14. A. Whittaker, *Abortion, sin and the state in Thailand* (London: Routledge, 2004).
15. *Ibid.*, p. 18.
16. Whittaker (2002, see note 9).
17. N. Boonthai, *Summary of the project to prevent mortality due to unsafe abortion and the development of the Medical Council regulation on therapeutic termination of pregnancy in accordance with the Criminal Code Article 305, 2005* (Nonthaburi: Department of Health, Reproductive Health Division, 2006).
18. Boonthai et al. (see note 11), p. 225.
19. *The Thai Medical Council's Regulation on Criteria for Performing Therapeutic Termination of Pregnancy in accordance with Section 305 of the Criminal Code of Thailand*, B.E. 2548 (2005). Available at <http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Thailand%20Medical%20Council%20Regulations%20in%20English.pdf>.
20. "Panel issues Zika guidelines to docs," *Bangkok Post* (October 6, 2016). Available at <http://www.bangkokpost.com/news/general/1103301/panel-issues-zika-guidelines-to-docs>.
21. Chaturachinda (see note 1), p. 4.
22. Bureau of Reproductive Health, Ministry of Public Health, *The administration of mifepristone and misoprostol in Thailand* (Bangkok: Ministry of Public Health, 2015).
23. United Nations High Commissioner for Refugees, *UNHCR Country Operations Profile: Thailand* (2011). Available at <http://www.unhcr.org/pages/49e489646.html>; Thailand Burma Border Consortium, *Burmese border displaced persons: June 2011* (2011). Available at <http://www.tbtc.org/camps/2011-06-jun-map-tbbc-unhcr.pdf>.
24. M. Hobstetter, M. Walsh, J. Leigh, et al., *Separated by borders, united in need: An assessment of reproductive health on the Thailand-Burma border* (Cambridge, MA: Ibis Reproductive Health, 2012); S. Belton and C. Maung, "Fertility and abortion: Burmese women's health on the Thai-Burma border," *Forced Migration Review* 19/5 (2004), pp. 36–37; J. Gedeon, S. N. Hsue, M. Walsh, et al., "Assessing the experiences of intra-uterine device users in a long-term conflict setting: A qualitative study on the Thailand-Burma border," *Conflict and Health* 9 (2015), pp. 1–7; S. Belton and C. Maung, *Working our way back home: Fertility and pregnancy loss on the Thai-Burma border* (Mae Sot: Mae Tao Clinic, 2005); M. Hobstetter, C. Sietstra, M. Walsh, et al. "In rape cases we can use this pill: A multimethods assessment of emergency contraception knowledge, access, and needs on the Thailand-Burma border," *International Journal of Obstetrics and Gynaecology* 130 (2015), pp. E37–E41; C. Beyre, "Shan women and girls and the sex industry in Southeast Asia: Political causes and human rights implications," *Social Science and Medicine* 53/4 (2001), pp. 543–550; J. Gedeon, S. N. Hsue, and A. M. Foster, "I came by the bicycle so we can avoid the police: Factors shaping reproductive health decision-making on the Thailand-Burma border," *International Journal of Population Studies* 2/1 (2016), pp. 78–88.
25. G. Arnott, R. K. La, E. Tho, et al., *Establishing a safe abortion referral system for women from Burma residing in Chiang Mai, Thailand: Results from situation analysis re-*

search (Cambridge, MA: Cambridge Reproductive Health Consultants, 2015); Hobstetter et al. (2012, see note 24).

26. Burma Penal Code (1860), §312A.

27. Global Justice Center, *Domestic criminal laws that conflict with international law: Myanmar's abortion and rape laws: A case study* (New York: Global Justice Center, 2012).

28. G. Sheehy and A. Foster, "Physicians' experiences with and opinions of abortion provision in Yangon, Myanmar" (National Abortion Federation, 41st Annual Meeting, Montreal, Canada, 2017).

29. K. Ba-Thike, "Abortion: A public health problem in Myanmar," *Reproductive Health Matters* 9 (1997), pp. 94–100; G. Sheehy, Y. Aung, and A. Foster, "'We can lose our life for the abortion': Exploring the dynamics shaping abortion care in peri-urban Yangon, Myanmar," *Contraception* 92 (2015), pp. 475–481.

30. S. Belton, "Borders of fertility: Unplanned pregnancy and unsafe abortion in Burmese women migrating to Thailand," *Health Care for Women International* 28/4 (2007), pp. 419–433; S. Lanjouw, *A report on the health situation at the Thailand-Myanmar border* (Chiangmai: World Health Organization, Regional Office for South East Asia in Thailand, 2001).

31. A. M. Foster, G. Arnott, M. Hobstetter, et al., "Establishing a referral system for safe and legal abortion care: Evaluation of a pilot project on the Thailand-Burma border," *International Perspectives on Sexual and Reproductive Health* 42/3 (2016), pp. 151–156.

32. G. Arnott, E. Tho, N. Guroong, et al., "To be, or not to be, referred: Access to legal abortion care in Thailand for women from Burma" (under review).

33. Chaturachinda (see note 1), p. 3.

34. S. Warakamin, N. Boonthai, and V. Tangcharoensathien, "Induced abortion in Thailand: Current situation in public hospitals and legal perspectives," *Reproductive Health Matters* 12/Suppl 24 (2004), pp. 147–156.

35. *Ibid.*

36. K. Damrongplasit and G. Melnick, "Funding, coverage, and access under Thailand's universal health insurance program: An update after ten years," *Applied Health Economics and Health Policy* 13 (2015), pp. 157–166; M. Reich, J. Harris, N. Ikegami, et al. "Moving towards universal health coverage: Lessons from 11 country studies," *Lancet* 387 (2016), pp. 811–816.

37. V. Tangcharoensathien, K. Chaturachinda, and W. Im-em, "Commentary: Thailand: Sexual and reproductive health before and after universal health coverage in 2002," *Global Public Health* 10/2 (2015), pp. 246–248; Chaturachinda (see note 1), pp. 2–7.

38. Chaturachinda (see note 1), p. 4.

39. *Ibid.*, p. 6.

